INSTRUCTIONS FOR COMPLETION OF THE DELAWARE ADULT HIV/AIDS CASE REPORT FORM
August 2009

The HIV/AIDS case report form (CRF) is Delaware's version of the CDC 50.42A and now replaces all prior HIV and AIDS case report forms for age 13 and over with HIV infection or AIDS. (A separate white form CDC 50.42B is used for reporting HIV/AIDS in persons under age 13.) More copies of the form may be obtained through your local health department or by contacting the HIV Surveillance Section at either 302-744-1015 or 302-744-1016.

All patients with evidence of HIV infection, including AIDS, should be reported within 7 days of diagnosis, including a physician diagnosis based on history and symptoms. AIDS cases (1993 CDC AIDS case definition) include all patients with a history of HIV infection who also have documented CD4 levels under 200 cells/microliter or a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14%, or any of the AIDS indicator diseases listed in Section X of the form. **All required information has been emphasized below in bold print.**

Completed forms should be mailed to:
Division of Public Health
Att: Surveillance
417 Federal St
Dover, Delaware 19901

When mailing the form, please address the envelope to the AIDS Coordinator or other designated local contact, and mark the envelope "Confidential" and "To Be Opened By Addressee Only."

SIDE 1

SECTION I. Health Department Use Only

Please leave this section blank for state health department

SECTION II. Patient Identifier Information

For confidential testers, enter the patient's full name, social security number, phone number and current address. If available, record a.k.a, aliases, etc. in Section XIII Comments.

SECTION III. Form Information

Please provide contact information for the individual who could be reached to answer questions concerning the information provided on the CRF. This person can be a physician, nurse, or any confidentiality-trained staff member with knowledge to interpret and access the patient's medical information.

SECTION IV. Current Provider Information

Please provide the physician, facility and phone where the patient is currently receiving care. If possible, provide medical record number and the date the patient was first seen at this facility and the date of their last (most recent) visit to the facility.

SECTION V. Demographics

Check the appropriate box under Diagnostic Status whether you are reporting "HIV Infection (not AIDS)" or "AIDS" (the patient meets the 1993 CDC AIDS definition; see introduction to these instructions for the definition of AIDS). All information that follows should correspond to the diagnostic status specified (HIV or AIDS). List US Dependents and Possessions. "Residence at Diagnosis" field should reflect when HIV or AIDS was first diagnosed.

Note: Ethnicity and race are two different variables. The appropriate box must be checked for each variable. If applicable, more than one race may be selected.

SECTION VI. Facility of Diagnosis

Enter the name of the provider and the address, city and state of the facility where the patient was first diagnosed (as HIV positive or as AIDS, accordingly). Facility type should also be specified with public clinics, counseling and testing sites and community based organizations written in as "other."

SECTION VII. Patient History

Check ALL boxes in appropriate columns. Indicate dates of first and last blood transfusion if applicable. Write in specific occupation if patient is a healthcare worker.

SECTION VIII. Additional Patient or Demographic Information

Please provide any additional information which may assist public health officials with the location, demographic background and behavioral history of the patient.

SECTION IX. Documented Laboratory Data

Please indicate the first documented positive, negative and/or indeterminate HIV test result. Include specific EIA and Western blot antibody tests and other virus detection tests.

Please record both the earliest and most recent viral load tests and indicate the test type (00-06).

Please record the CD4 cell count and percent closest to the current diagnostic status as well as the first CD4 count/percent less than 200/ul or less than 14%. Include date of all tests.

Test date refers to the date specimen was collected.

If laboratory documentation of a positive HIV test is unavailable in the medical record, enter the date of physician diagnosis of HIV infection. A physician diagnosis is made by clinical and/or laboratory evaluation and should be clearly documented (e.g., in progress notes). Prescription of anti-retroviral drugs is sufficient evidence of a physician diagnosis of HIV infection.

Please indicate if the patient has received an HIV genotype testing and if possible the date and lab at which the testing was conducted.

SECTION X. AIDS Indicator Diseases

Please indicate whether the clinical record was reviewed. **For AIDS reports, check all known indicator diseases and enter dates of diagnosis. Specify whether presumptive or definitive.** (Definitive diagnoses are generally based on specific laboratory methods, while presumptive diagnoses are those made by the clinician. A complete description may be found in the MMWR supplement RR-17, Vol. 41, December 18, 1992).

SECTION XI. Treatment/ Services Referrals

Complete all partner services questions. They are: "Has the patient been informed of their HIV infection?" and "Who will counsel the patient's partners about their HIV exposure?" (both found within the bolded box in this section).

For patients diagnosed with HIV, please check a box under HIV that corresponds to the primary method that the patient's HIV care will be reimbursed. For patients diagnosed with AIDS, please check a box under AIDS that corresponds to the primary method that the patient's AIDS care will be reimbursed.

If you are aware of a clinic-based or clinical trial in which the patient participates, please indicate it by name.

Enter whether referrals have been made for HIV medical services and/or substance abuse treatment services.

SECTION XII. Women Only

For women, list all known obstetrical information as requested. **Please indicate whether the patient is currently pregnant and list their EDC or due date.** Provide birth information, if applicable, for their most recent birth: child's date of birth and address of birth hospital. Enter "home birth" if born at home and include the full name of the child.

SECTION XIII. Tratment, Referral or Other Comments

Please add any additional laboratory, clinical, or partner counseling and referral service information here.